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Medicaid Process Reform for Nursing Facilities:

Creating an Accurate, Consistent and Timely Reimbursement System

Introduction

The process for paying for nursing facility residents eligible for Medicaid is a cost-based reimbursement process—i.e., providers spend money to take care of Medicaid beneficiaries, the providers receive payment based on daily rates established by the state for Medicaid beneficiaries residing in skilled nursing facilities, annual audits are conducted to ensure that the expenditures were allowable Medicaid expenditures, and any over or under expenditure ultimately gets settled with the state Medicaid system.

Recognizing the important roles of ensuring quality care for nursing facility residents and fulfilling its fiduciary responsibility to taxpayers, the state should also ensure that its reimbursement process for providers is fair, responsive, efficient, timely, and free of unnecessary cumbersome requirements.

Unfortunately, this is not fully the case with the current nursing facility Medicaid reimbursement process. The goal of this legislation is to create an accurate, consistent, and timely reimbursement process that maintain the need to ensure quality care and taxpayer accountability.

SB 1037 (MacGregor) —Due Process and Improvements to Medicaid Reimbursement Policy

SB 1037 would ensure due process when the state changes how they interpret Medicaid policy, and make other important policy revisions.

Prohibit Retroactive Policy Reinterpretations

MDHHS publishes its Medicaid provider policies in the Medicaid Provider Manual, which is updated quarterly. New policies are established through a process that allows providers the opportunity to comment on the proposed policy, and are given a future effective date to allow for providers to prepare for the policy.

The department has often reinterpreted policy and applied the changes retroactively. This retroactive application of a "reinterpretation" of existing policy without provider knowledge violates fundamental principles of fairness and due process. SB 1037 would require reinterpretations to have a prospective effective date.

Encouraging the Modernizing of Skilled Nursing Facilities

Nursing facilities need the ability to respond to market demand by periodically reconfiguring room layouts for the purpose of creating more home-like environments and greater privacy. This often involves converting small rooms and multi-bed wards to private rooms, smaller and more intimate dining settings, and modernized rehabilitation areas. The reconfiguration and modernization of facilities significantly benefits residents.

Current Medicaid policies, however, create two significant disincentives for modernization. One is that the removal of a bed from a facility is essentially a ***permanent*** removal—after two years, the facility loses the right to add that bed back because of Certificate of Need (CON) restrictions. This arbitrary policy does not create the flexibility necessary to respond to market demand and acts as a disincentive to modernize facilities.

SB 1037 would update the current non-available bed plan to allow nursing facilities to place beds in the plan for up to 10 years, and also allow the beds to be noncontiguous. This will allow facilities to modify semi-private rooms to private rooms, as the market dictates.

The second significant disincentive to modernization is how Medicaid treats capital costs. The Medicaid reimbursement rate includes a capital value per bed—called the "capital asset value limit"— which is essentially an attempt to value the facility itself. The determination of that asset value limit is extremely antiquated and does not reflect the cost of building or replacing today – in fact, the current calculation of this part of the Medicaid reimbursement rate is a data base going back to 1975. This acts as a disincentive to modernize, because current replacement or modernization costs are much higher.

SB 1037 would update the capital asset value limit by establishing a 10 year rolling average to compute the capital asset limit.

Make Simple Fix to End Payment Delays

Most Medicaid beneficiaries in skilled nursing facilities are elderly residents who will always need that level of care. But some Medicaid beneficiaries are residents for other reasons related to health—a relatively young person suffering from drug abuse, for example. The facility is still reimbursed by Medicaid, but situations occur which prevent the provider from being reimbursed in a timely manner.

A person described above might be enrolled in a Medicaid managed care organization—i.e., a Medicaid health plan. In those cases, that person is limited to 45 days of skilled nursing care through the Medicaid health plan, after which the person is "disenrolled" from the managed care Medicaid reimbursement process and is now reimbursed under the fee-for-service Medicaid reimbursement process.

When a Medicaid beneficiary changes status by disenrollment from a health plan to fee for service, the "care code" in the state's payment system—CHAMPS—must be changed to reflect the new status to enable a provider to receive payment for services. Currently the process can take as long as 9 months to complete, which leaves the service provider unable to receive payment during this time. This unnecessary delay is the result of the fact that each code change is currently reviewed by one person in the MDHHS.

SB 1037 would require the MDHHS to establish a process to automatically make this simple code change to enable the provider to receive timely reimbursement for the skilled care provided.

Create a Stakeholder Workgroup

The many issues related to Medicaid reimbursement to skilled nursing facilities require a regular discussion between providers of care and the state Medicaid office. SB 1037 would require the MDHHS to establish a Medicaid Process Reform workgroup of nursing facility providers, provider associations and the department to discuss and resolve various policies and procedures related to Medicaid. The workgroup would meet quarterly, with the stated goal being to create an accurate, consistent, and timely reimbursement process.

SB 1038 (Stamas) — Timely Medicaid Cost Reports, Audit, and Settlement Process

The Michigan Medicaid program reimburses skilled nursing facilities for Medicaid-approved services at a rate determined annually by the state Medicaid office each October. Billing by the provider occurs once a month, and the state generally pays within two weeks of receiving the monthly billing.

Every facility in the state is required to submit an annual "cost report" to the state Medicaid office within 5 months of the end of the facility's fiscal year, which is the calendar year for most facilities. This cost report contains the expenses incurred by the facility, as well as the accounting for those expenses. These cost reports are audited by the state to ensure that the reimbursement to the particular facility throughout the year has been for Medicaid-eligible expenses and otherwise comply with Medicaid policy. Audits can be limited-scope or onsite. With few exceptions, every annual cost report from every facility is audited.

The final step in the process is a "settlement," which is the matter of reconciling the annual cost report submitted by the facility with the audit conducted by the state.

A fundamental ongoing problem is that audits—and, therefore, settlements—are not being completed on a timely bases. In fact, it is not unusual for audits to take several years to even begin.

SB 1038 would not only establish specific time frames for the completion of the audit and final settlement, but also create requirements for the state to meet those deadlines. Currently, cost reports are due to MDHHS five (5) months after the completion of the

provider's cost reporting fiscal year, and the state has the authority to stop payments to facilities that do not meet that deadline. SB 1038 would maintain that requirement and specify that an audit and final settlement must be completed within 21 months of the accepted cost report. If an audit is not completed within the 21 month schedule, the department must accept the cost report as filed and issue a settlement within 60 days.

For example, calendar year end cost reports are due by May 31. Therefore, SB 1038 would require that the cost reports covering calendar 2017 be accepted by July 31, 2018, the audit must be completed by April 30, 2020 and a settlement made by June 30, 2020. MDHHS estimates they are able to complete 2017 cost report audits in 12 months. SB 1038 gives the department 25 months to complete the audit – double the time required as estimated by DHHS.

Requiring the timely completion of audits going forward, however, does not resolve the current backlog of uncompleted audits. SB 1038 addresses the backlog by requiring the department to finish all audits outstanding on the date the new law becomes effective within two years of that date. The cost report filed by the provider shall be accepted as filed for any of those audits not completed within the two years and settlements issued within 30 days.

SB 1038 would also require that a customer satisfaction survey be provided quarterly to facilities after each on-site audit to give the nursing facility an opportunity to provide MDHHS Office of Audit feedback on audit activity.

Field audits often result in the auditors requesting documentation that the provider doesn't—and wasn't aware they were required to – readily maintain and is, therefore, difficult and time-consuming to create.

SB 1038 provides clarity to the documentation necessary by specifying that any documentation requested must be that required by the Medicaid state plan, the Medicaid provider manual, and the Code of Federal Regulations relating to Medicare/Medicaid.

Different auditors sometimes apply Medicaid reimbursement policy in different ways, which results in inconsistency across the state and across skilled nursing facilities. SB 1038 would require the department to establish an ongoing review of all audit adjustments and identify and correct any inconsistencies.

The delays in audit completion have existed for many years. SB 1038 would require an independent analysis on the efficiency and cost effectiveness of the overall audit process, as well as an outside evaluation of the effectiveness and efficiency of having audits done by an outside contractor.

SB 1038 would also require quarterly reports to the legislature on both the progress of timely audit completion under the new schedule, as well as the completion of the existing backlog of audits.

SB 1039 (Hansen)—Streamline the Determination of Medicaid Eligibility

Senate Bill 1039 addresses several issues related to Medicaid eligibility: (1) initial eligibility; (2) annual redetermination of eligibility; (3) divestitures (4) outstation worker availability; and (5) court-ordered payment.

Initial Eligibility

The state has a responsibility to ensure that only truly eligible individuals receive Medicaid, but it also has a duty of doing so promptly to ensure that providers are properly and timely paid for eligible services. The application for Medicaid is actually made at the county office of the MDHHS and is basically a process of verifying existing income and assets the potential beneficiary may own.

The Medicaid program has a 45-day "Standard of Promptness" for determining Medicaid eligibility. This standard is not only required in the federal Medicaid guidelines, but is also required in the FY 2018 Appropriations Act for the Michigan Department of Health and Human Services (MDHHS)—PA 107 of 2017.

The problem is that the state is not meeting this 45 day standard when it comes to determining Medicaid eligibility for residents of many nursing facilities--in fact, for some areas of the state Medicaid nursing facility applications take ***far longer*** than the 45 day standard. During this time of pending eligibility, the nursing facility is providing all of the care needs for the resident without receiving any reimbursement; a cash flow burden which obviously increases the longer it takes to determine Medicaid eligibility.

SB 1039 would establish staff at the MDHHS county offices dedicated to Medicaid eligibility cases for residents of nursing facilities. The MDHHS must report on the compliance of the standard of process by county to providers and the legislature.

Annual Redetermination of Medicaid Eligibility

Federal law requires that all Medicaid beneficiaries—including nursing facility residents – be re-determined for Medicaid eligibility annually. In the case of nursing facility residents, the current process is long, complicated, and often frustrating for the resident and the assisting family—in spite of the fact that rarely, if ever, has a re-determination for a long staying resident shown that the individual is no longer eligible. This is a function of the fact that the typical long-stay nursing facility resident is over 82 years old and has multiple chronic illnesses – with a significant number having some degree of dementia.

In some parts of the state—Wayne County, for example—the complexity and time required of the current process often causes the resident to be actually disenrolled from Medicaid for not providing information that hasn't changed. This can cause an emotional, financial, and at times even physical hardship for the resident and the family.

The current reenrollment process also causes more work for state employees who could better use that time for more pressing and serious matters requiring their attention.

SB 1039 would create a simplified re-determination process, including electronic asset detection to verify income and asset status. It would not only be as accurate as the current system, but it would reduce the burden on the resident and their family, and at the same time free state workers to spend time on more important issues.

Eligibility and Unknown Divestitures

Some individuals admitted to a skilled nursing facility who apply for Medicaid incur what is called a "divestiture penalty period." This refers to a period of time that Medicaid refuses to reimburse the facility for the resident's care, and is typically applied because the MDHHS has determined that the individual has improperly divested or transferred assets that should have been used to pay for the nursing facility stay prior to the use of Medicaid.

The problem for the provider of care is that the imposition of this divestiture penalty period often becomes known long after the person has been admitted to the facility. This can occur, for example, because a resident is often first admitted for a Medicare covered stay. Once the Medicare coverage ends, many residents will then have begun the Medicaid application process, which only then discloses the divestiture penalty.

More fundamentally, the care provider—in this case, the skilled nursing facility—is essentially being used by the Medicaid system to get into the Medicaid financial recovery business. It is unfair to financially penalize the nursing facility provider for improper financial actions of the Medicaid applicant, particularly since the nursing facility has been providing care to the resident in good faith, was probably unaware of the imposition of the divestiture penalty period, and shouldn't become part of the Medicaid financial recovery process.

SB 1039 would create a fund to relieve some of the cost of care provided to residents under a divestment penalty. The rolling fund would be capped at $3 million and be dispersed annually to each facility claiming divestment penalty debt at a percentage covered by the fund.

Eligibility Assistance Contracting for Outstation Workers

MDHHS has a program in which certain state employees—called "Outstation Workers"—are assigned to assist a particular nursing facility with Medicaid eligibility processing. The facility is contractually obligated to reimburse the state for a significant portion of the costs related to this employee.

The problem is that the availability of these workers has varied over the past few years and the process to secure an outstation worker is not readily known to all nursing facility providers – in spite of the fact that most of the costs for the program are paid by the facility.

SB 1039 would require that an outstation worker to assist with Medicaid eligibility be made available to any facility that requests one.